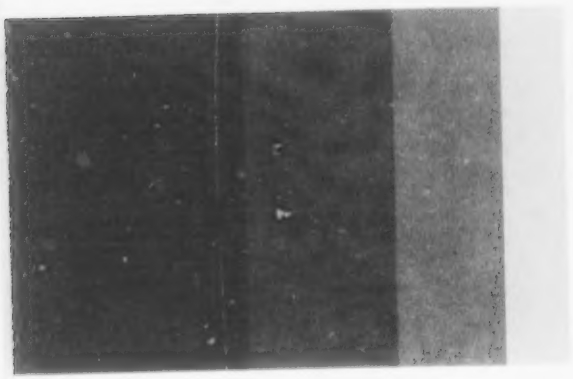
G51

HCEA GLOSSARY



HE 22.2.

Prepared by
Office of
Management
and Budget

Office of
Management
Services

Health Care
Financing
Administration

TABLE OF CONTENTS

I. Glossary of Program Terminology 1

II. Medicaid 8

III. Medicare 18

IV. Quality of Care 28

GLOSSARY OF PROGRAM TERMINOLOGY

1. **Assignment**—is the agreement of the physician/supplier to accept the reasonable charge, for services rendered to a beneficiary, from Medicare as payment in full. The physician/supplier cannot bill the beneficiary for more than 20% of the reasonable charge. The physician/supplier may also bill the beneficiary for any deductible which has not been satisfied. (Applies to Part B only)

2. **Benefit Period**—A benefit period in the Medicare program begins the first day a beneficiary receives inpatient hospital or extended care services from a qualified provider and ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. Any inpatient stay—whether covered by Medicare or not—extends the benefit period. In each benefit period, Medicare pays for up to 90 days of inpatient hospital care, 100 days of SNF care, and 100 home health agency (HHA) visits. These benefits are subject to deductibles, coinsurance, and prior hospital stay requirements.

3. **Coinsurance**—The portion of reimbursable hospital and medical expenses, after subtracting any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount, and under Part B, it is a percentage of reasonable charges.

a. Part A

Hospital—From the 61st through the 90th day, the daily coinsurance amount is equal to ¼ of the inpatient hospital deductible.

Lifetime Reserve—For each of the 60 lifetime days used, the daily coinsurance amount is equal to ½ of the inpatient hospital deductible.

SNF—From the 21st through the 100th day, the daily coinsurance amount is equal to ⅛ of the inpatient hospital deductible.

b. Part B

After the annual deductible has been met, Medicare pays 80 percent or reasonable charges for covered services and supplies. The remaining 20 percent of reasonable charges is the coinsurance.

4. Concurrent Review (CR)—PSROs review institutionalization of Federal patients while they are in the facility through both admission certification and continued stay reviews.

5. Conditional PSRO—An organization that, having demonstrated its capability to perform the duties of a fully designated PSRO, enlisted the membership of at least 25 percent of area physicians, developed a review and implementation plan, and met other PSRO organizational requirements, has been awarded a contract to implement the required review and other functions in its designated area.

6. Disallowance—is the formal notification to a state that HCFA has determined a claim for federal reimbursement under Title XIX to be unallowable.

7. Deductible

a. Part A—Inpatient hospital deductible—An initial amount in each benefit period (reflecting the national average charge per day in a hospital) which Medicare does not pay.

b. Part B—A dollar amount per calendar year which must be incurred for Part B expenses before Medicare starts to pay. Expenses incurred in

the last 3 months of a year which are applied toward the deductible for that year may also be used toward the deductible for the following year.

8. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)—A mandatory service program for individuals under 21 who are eligible under the State Medicaid program, created by the 1967 amendments to the Social Security Act. Stressing the importance of preventive health care services, States are required actively to seek out Medicaid-eligible children in need of health care (informing and outreach), assess their needs (screening), and see that the necessary diagnostic and treatment services are received.

9. Fully Designated PSRO—An organization that has performed satisfactorily as a conditional PSRO is performing hospital review, and has been granted full status as specified in the law.

10. Group Practice Prepayment Plan—An organization which has a formal arrangement with the equivalent of three or more full-time physicians to provide certain health services to members in return for a predetermined, periodic premium. Must meet prescribed criteria for participating in Medicare and Medicaid. Medicare payments may be made directly by HCFA only for Part B services.

11. Health Maintenance Organization—An entity that collects regular premiums from its members and, in turn, provides any needed inpatient or medical services for little or no additional charge. Must meet prescribed criteria for participating in Medicare and Medicaid. Medicare payment is made directly by HCFA rather than through a carrier or intermediary.

12. Home Health Agency (HHA)—An agency which provides health care in

the home and meets certain requirements. Services may include part-time skilled nursing care and physical, occupational or speech therapy. Coverage is available under both Parts A and B of Medicare and under Medicaid.

13. Hospital—An institution which primarily provides to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons; or rehabilitation services to injured, disabled, or sick persons. Coverage is available under Part A of Medicare and under Medicaid. A wide range of outpatient services coverage is also available under Part B of Medicare and under Medicaid.

14. Intermediate Care Facility (ICF)—An institution which (1) is licensed under State law to provide regular health-related care and services to individuals requiring a level of care above that of room and board but less than that provided by a hospital or SNF; (2) meets prescribed standards for quality of care and safety; and (3) meets requirements for protection of patients' personal funds. Coverage is available under some State Medicaid programs but not under Medicare.

15. Level of Care (LOC)—To qualify for Medicare and Medicaid benefits for inpatient hospital, skilled nursing facility, intermediate care facility (Medicaid only), or home health services, a beneficiary must both *need* and *receive* a certain type and degree of health care (i.e., a certain "level of care"). This LOC will vary among the 4 types of providers. For Medicare or Medicaid reimbursement, both the type of provider and the care provided to the beneficary must be appropriate to the beneficiary's medical needs.

16. Lifetime Reserve—An additional 60 days of inpatient hospital care (to be used only once by the beneficiary) which may be drawn upon after using 90 days in a benefit period. This applies only to the Medicare program.

17. Long Term Care—Health and/or personal care services required by persons who are chronically ill, aged, disabled or retarded, in an institution or at home on a long term basis.

18. Maternal and Child Health Program—A State administered and joint State and federally financed assistance program established by Title V of the Social Security Act which is designed to reduce infant mortality and promote the general health of mothers and children.

19. Physician—A doctor of medicine, doctor of osteopathy, doctor of dental surgery or dental medicine, a chiropractor or doctor of podiatry or surgical chiropody, or doctor of optometry legally authorized to practice by a state in which he performs this function.

20. Planning PSRO—An organization which has demonstrated the potential to meet the requirements for conditional PSRO designation and has been awarded a contract for financial assistance to develop that potential by developing review and implementation plans, recruiting physician members, and collecting baseline data.

21. Profile Analysis—A type of PSRO review by which aggregated statistical data is used to identify areas where utilization practices may be inappropriate to focus concurrent review and to assist in the selection of ORS topics.

22. Provider—A hospital, intermediate care facility, skilled nursing facility, renal dialysis facility, home

health agency and, for the limited purpose of furnishing certain outpatient services, a clinic, rehabilitation agency, or public health agency which meets the applicable eligibility requirements for participating in the Medicare program.

23. Quality Review Studies (QRS)—A type of PSRO review by which a medical care topic is chosen for review, criteria and standards are established, data is collected and analyzed (usually retrospectively) to identify deficiencies, corrective action is implemented, and the topic is restudied.

24. Reasonable Charge—An individual Medicare charge determination made by a carrier for a covered Part B medical service or supply. In the absence of unusual medical circumstances it is the lowest of, (a) the physician's or supplier's customary charge for that service, (b) the prevailing charge for similar services in the locality, and (c) the actual charge made by the physician or supplier. This also forms a reimbursement ceiling for physicians under Title XIX.

25. Reasonable Cost—The basis for Medicare payments to participating providers. Reimbursement is based on the reasonable cost of providing services or the customary charges for such services, whichever is less. This concept also forms the basis for Title XIX reimbursement to hospitals and other facilities, but States can develop their own methods of calculating what is reasonable.

26. Skilled Nursing Facility (SNF)—An institution such as a skilled nursing home or rehabilitation center. It is designed for the patient who no longer needs the intensive care of a hospital but who still needs, on a daily basis, skilled nursing care or other skilled rehabilitation services for a condition

for which he/she received inpatient hospital services and which, as a practical matter, can only be provided in a SNF on an inpatient basis. To be certified as an SNF, the institution must meet certain conditions under Medicare and Medicaid.

27. Spend Down—Provision of Medicaid eligibility by which individuals' medical bills can be subtracted from their income until it is reduced to a level meeting requirements making them eligible for Medicaid. Spend down is applicable in 2 situations: (1) applicant can spend down to medically needy level in States covering the medically needy; (2) aged, blind applicants can spend-down to cash assistance level in States not using SSI criteria for determining eligibility.

28. State Buy-In—An agreement between a State and the Federal Government whereby a State may pay for/acquire Part B Medicare entitlement for certain Medicaid recipients by enrolling them and paying their premiums for them.

29. State Survey Agency—A State governmental agency that reviews facilities wanting to participate in the Medicare and Medicaid Programs to ensure that they give quality care and provide a safe environment, i.e., that they meet the program standards for participation.

30. Supplier—Any individual or entity other than a provider of service who furnishes items and/or services to Medicare beneficiaries.

31. Third Party Liability—A requirement under Title XIX program that State agencies take reasonable measures to collect payment for claims from other resources which are legally established as primary payors to Medicaid.

32. Unassigned Claim—When the beneficiary files a claim with Medicare and payment is made to him/her. The beneficiary is responsible for paying the physician/supplier. The physician/supplier may bill the beneficiary for more than the amount Medicare has determined is a reasonable charge. (This applies to Part B only)

MEDICAID

Medicaid, established by Congress in 1965 under Title XIX of the Social Security Act, is a State administered and joint State and federally financed medical assistance program for families with dependent children, and aged, blind or disabled individuals and the medically needy who are aged, blind, disabled, or have dependent children.

To be eligible for Federal Financial Participation (FFP), a State must develop and have approved by the Secretary a program plan that meets statutory and regulatory requirements:

- All Plans *must* include inpatient and outpatient hospital, outpatient laboratory and x-ray, skilled nursing, physician, family planning, rural health clinics, and EPSDT services. These services can be provided by institutions and groups such as hospitals, skilled nursing facilities, home health agencies, health maintenance organizations, and group practice prepayment plans.

- Additionally, each State can *elect* to cover other services such as prescription drugs, eyeglasses, clinics, dental services and intermediate care facility services, including ICF services for mentally retarded.

There are 54 Medicaid programs—one for each State (except Arizona); as well as Guam, Puerto Rico, the

Virgin Islands, the District of Columbia, and the Northern Mariana Islands.

Eligibility for Medicaid varies according to State plans, but is based on financial need, in combination with other factors:

- States *must* include *all* persons receiving cash benefits under Title IV-A of the Social Security Act (Aid for Dependent Children) *and either all* persons receiving cash benefits under Title XVI of the Act (Supplemental Security Income) *or* those who can meet additional, more restrictive, Medicaid eligibility conditions (categorically needy).
- States *can* include specified optional groups who cannot qualify for Title IV-A or XVI because their income is too high; but nevertheless, cannot afford needed medical care ("medically needy"). A separate income level is established for these groups and can include a spend down provision.

Each State's Medicaid Program is administered by a State governmental agency. That agency also may act as a fiscal agent for the payment of Medicaid claims, but that function can be contracted out to a private organization.

Mandatory services for the categorically needy must be provided without charge; optional services for the categorically needy and all services for the medically needy may be given with a nominal deductible or copayment. The Medicaid agency must have arrangements to assure that recipients can get to and from providers of care.

Physician reimbursement can be no higher than the reasonable charge limits of Medicare. Hospital reimbursement is on a reasonable cost basis, as with Medicare, with the ex-

ception of approved prospective reimbursement plans. Services of SNFs and ICFs must be reimbursed on a reasonable cost-related basis, but States may set their own methods, definitions, etc., used in calculating reimbursable costs as long as they are rational. Federal regulations require the payment of the full reasonable cost equated with efficient and economical operations.

FFP for medical services is based on the inverse ratio of per capita income of the State to that of the Nation as a whole, but the matching rate is never less that 50 percent nor more than 83 percent. FFP for administrative functions varies according to the function, but is uniform for all States.

Congress annually appropriates the Federal share of program costs from general revenues. State legislatures annually appropriate the State share with some States including local funds in this amount.

Medicaid is administered and monitored through the following operational programs.

Maximum Allowable Cost—MAC

Purpose:

• To control cost of prescription drugs.

Description:

• Part 19 of Title 45—Public Welfare, Code of Federal Regulations published in 1975 limiting reimbursement for drugs under Medicare, Medicaid and PHS programs.

—maximum allowable cost limits, based on the lowest price at which an equivalent drug is widely and consistently available, to be placed on reimbursement for multi-source drugs.

—actual acquisition cost reimbursement for single source drugs.

—publication and distribution of a *Guide to Prescription Drug Prices* that

compares the costs to pharmacists of frequently prescribed products.

Operation:

- Pharmaceutical Review Board, Bureau of Program Policy, establishes and publishes limits in the Federal Register.
- Medicaid State agencies implement the limits in paying claims.
- HCFA Regional Offices monitor implementation.

Medicaid Management Information System—MMIS

Purpose:

- To improve the capability of the Title XIX State agency to administer the Medicaid Program by effectively processing and controlling claims and by providing management with the information necessary for planning and control.

Description:

- A general design of an automated claims processing and management information system, composed of six subsystems to be designed in detail and implemented by State agencies:

—Recipient Subsystem (RS)—identifies all recipients eligible for Medicaid.

—Provider Subsystem (PS)—processes and enrolls in the Medicaid Program providers who have agreed to comply with Title XIX rules and regulations.

—Claims Processing Subsystem (CPS)—ensures that all transactions are processed completely and promptly, all claims discrepancies are resolved expeditiously, and correct and timely payments are made to providers.

—Reference File Subsystem (RFS)—provides generalized update facility for various files used in claims proc-

essing, including usual and customary charge data.

—Surveillance and Utilization Review Subsystem (SURS)—comprehensive statistical profile of health care delivery and utilization patterns.

—Management and Administrative Reporting Subsystem (MARS)—provides State agency with information to support the management review, evaluation, and decisionmaking process.

- RS, PS, CPS and RFS function as an integrated unit with the overall objective of processing and paying each eligible provider for all valid claims on any eligible recipient.
- SURS and MARS are basically concerned with data consolidating, organizing and presenting data in a concise, meaningful manner to enable management to effectively control its Title XIX program.

Operation:

- HCFA provides system specifications in the form of functions and objectives to be met. States do the detailed design, develop, and implement systems.
- The Federal Government pays 90 percent of costs of developing and implementing an MMIS and 75 percent of the cost of operating certified system.
- BPO reviews systems to determine compliance with specifications, advises State agencies of needed modifications, and signs and issues certification letters.
- Bureau of Program Operations signs and issues certification letters. Decisions currently are based on compliance with specifications.

Medicaid Minimum Data Set (MMDS)

Purpose:

The Medicaid Minimum Data Set (MMDS) was an effort by HCFA to

identify its management data needs for the Medicaid Program. The reporting requirements developed under MMDS are being implemented in the form of revised HCFA-120 and 2082 reports. The revised HCFA-120 report was effective for the month of April 1980 while the revised HCFA-2082 report will be effective for FY 1980.

Description:

Types of data to be reported under the reporting requirements developed under MMDS include:

- Counts of individuals eligible for Medicaid.
- Counts of Medicaid recipients.
- Amounts of Medical Vendor Payments.
- Number of Medicaid claims approved for payment.
- Number of service units paid for by Medicaid.

Operation:

- HCFA developed reporting specifications.
- States collect data and prepare report.
- Reports received and processed by ORDS.
- BPO responsible for delivering technical assistance to assist States in implementing MMDS.

State Assessments—SA

Purpose:

- To evaluate the performance of Medicaid State agencies, identify significant problems, and recommend corrective actions.

Description:

- A program for annually evaluating Title XIX State agencies.
- Eight core areas are to be reviewed each year:

—Claims Processing/Third Party

Liability/Abortions, Sterilizations and Family Planning

—Eligibility

—Reimbursement/Financial Management

—Utilization Control

—Provider Enrollment/Relations

—Administration and Management/Service Delivery

—EPSDT

—Fraud and Abuse (including post-payment review standards/mechanisms to control abuse)

Operation:

- ROs review State agency performance in the core areas, either as one comprehensive review or on a time-phased basis over the year, depending on RO preference.
- ROs advise States, BPO and BQC of State performance, recommend and track State corrective actions, publish results of assessments in the Annual State Evaluation Report.
- BPO reviews RO findings to identify trends and develop standards.

Annual State Evaluation Report—ASER

Purpose:

- To publish the results of State Assessments.

Description:

- Formal report of findings and evaluation of Medicaid State agency performance based on the State assessment and any other annual reviews.

Operation:

- ROs write the reports based on assessment results and use them in negotiations with the States to correct deficiencies.
- BPO and BQC use the report to identify national trends, general/corrective action needs, and exemplary practices for use in other States.

Medicaid Quality Control System—MQC

Purpose:

- To assess State performance in Medicaid eligibility determinations, third party recoveries, and claims payment.

Description:

- A State operated and federally monitored system designed to evaluate and improve the State agency's administration of its Medicaid Program.
- Assesses performance in the areas of eligibility, claims processing and third party liability determinations.
- HCFA accepts eligibility quality control reviews on AFDC and SSI. HCFA does its own eligibility review for medical assistance only. Additionally, HCFA reviews all three strata for claims processing and third party liability.

Operation:

- State pulls and reviews statistically reliable Statewide sample of Medicaid cases.
- State calculates error rates in each category based on results. HCFA ROs re-review a subsample and transmit results of their re-reviews as well as the State reviews to BQC through the Datamed System.
- BQC calculates error rates for each State in each performance category for 6 month periods based on both State and Federal findings and assesses penalties for failure to reduce eligibility error rates according to prescribed standards.

EPSDT Quality Control System

Purpose:

- To assess and improve State administration of the EPSDT (Early and Periodic Screening, Diagnosis, and

Treatment of individuals under 21) Program.

Description:

• A federally operated system designed to assess States' conformance with the following program requirements:

—Inform newly eligible AFDC families about the benefits of EPSDT and reinform annually those families who choose not to participate in the program.

—Arrange for, or provide, initial medical screening and dental services when requested by AFDC families and periodically re-examine recipients that have been screened.

—Arrange for, or provide, treatment for conditions which were disclosed during screening.

Operation:

• Regional offices review State administrative materials and statistically reliable statewide samples of EPSDT cases.

• BQC calculates State conformance with EPSDT program requirements.

• BQC analyze data, recommends corrective actions designed to improve EPSDT program administration, and recommends penalties for States failing to meet prescribed standards of EPSDT program implementation.

Validation Review Program

Purpose:

• To control abuse and waste in the Medicare program.

Description:

• A comprehensive program designed to identify or substantiate suspected

—improper practices by institutional and non-institutional health care providers which have resulted in the payment of incorrect, excessive program funds.

—failure on the part of Medicaid State

agencies to meet their responsibility to adequately detect and control program fraud and abuse by providers.

—weaknesses in program policy and/or its implementation which result in monies being improperly paid.

Operation:

• BQC and Regional Offices conduct onsite reviews of providers' billing practices and Medicaid State agencies' program payment processes.

• BQC, based on review findings, makes recommendations to appropriate components for corrective actions, e.g.,

—recovery of program overpayments.

—investigations of potential provider fraud.

—revision of current instructions, policies, regulations or legislation.

—improvement of existing Medicaid State agency operations.

Administrative Sanctions:

Purpose:

• To ensure that Medicaid Program funds are not paid to individual providers of medical services/supplies found to have defrauded or abused the program.

Description:

• Medicaid State agencies, on the advice of BQC, take sanction action against a provider if the provider is convicted of a criminal offense(s) related to participation in the program.

Operation:

• Regional Offices identify providers for suspension, termination, or exclusion from program participation and forward proposals to BQC.

• BQC sets length of suspensions and advises State agencies; State agencies notify providers of suspension (length of suspension may be increased by State agency).

• BQC takes action on requests by providers for program reinstatement after suspension term and notifies State agencies that they may (but are not required to) reinstate the providers.

MEDICARE

Medicare, established by Congress in 1965 under Title XVIII of the Social Security Act, is a federally administered and financed health insurance program for people 65 and older and some people under 65 who are disabled or suffer from end stage renal disease. Medicare has 2 parts:

• *Part A*—Hospital Insurance (HI)—helps pay for medically necessary inpatient hospital care and, after a hospital stay, for inpatient care in a skilled nursing facility and for care in the home by a home health agency.

• *Part B*—Supplementary Medical Insurance (SMI)—helps pay for medically necessary doctors' services, outpatient hospital services, outpatient physical therapy and speech pathology services, services provided by a Group Practice Prepayment Plan or Health Maintenance Organization, outpatient maintenance dialysis and home dialysis equipment and supplies required by patients with end stage renal disease, home health services when Part A will not cover them, and a number of other medical services and supplies that are not covered by Part A.

Entitlement for part A is automatic for anyone 65 or older receiving Social Security benefits, as well as for those who are entitled to Social Security or Railroad Retirement Disability benefits if they have been considered disabled for 2 years. Those people who have undergone renal dialysis or a kidney transplant are entitled to

Part A if they have the required work under Social Security or Railroad Retirement or are the spouse or child of someone who does. Also, States can choose to buy into Part B coverage for their Medicaid beneficiaries.

Medicare payments are handled by private insurance organizations under contract with the Secretary. *Intermediaries* are those organizations under contract to provide reimbursement on a reasonable cost basis to hospitals, SNF's and HHAs. Providers nominate the intermediary they wish to use; those wishing to deal directly with the Federal government are served by HCFA Office of Direct Reimbursement. *Carriers* are those organizations under contract to handle Part B claims for physicians and supplier services, within a specified geographical area.

Payment for services covered by Part A is made by an intermediary to the provider of care based on the reasonable cost of that care and the fact that a beneficiary is in a benefit period or utilizing lifetime reserve days. The beneficiary is responsible for paying an initial amount (deductible) in each benefit period, as well as a certain portion of each day's cost after passage of a certain number of days. Interim payments are made to each facility based on the submission of individual bills or based on a prior year's volume of Medicare business. Final payment is made annually by the intermediary based on the provider's submission of an annual cost report which is reviewed and settled by the intermediary.

Payment for services covered by Part B is made by the carrier to the beneficiary, physician, or to a supplier of services who agrees to accept assignment based on a reasonable charge for supplying the service. No benefit period applies in Part B; in-

stead, the beneficiary is responsible for an annual deductible as well as coinsurance on all covered services. The carrier makes payments based strictly on individual claims with no annual cost report or cost settlement process.

The majority of Medicare funding comes from the Title XVIII Trust Funds (Separate Hospital Insurance and Supplementary Medical Insurance Trust Funds exist). Expenses for disabled persons, with certain exceptions, are paid from the Disability Trust Fund. For Part B, premiums are set by law with an annual inflator linked to the increase in OASI benefits. The amount needed to make up the balance of Part B payments in excess of premium payments is then appropriated to the Trust Fund from general revenues. Medicare is administered and monitored through the following operational programs.

Medicare Contractor Productivity Improvement Program—MCPI

Purpose:

- To decrease costs of Medicare contractors' operations without sacrificing quality.

Description:

- A program that uses the contractor budgeting process to achieve more effective and efficient contractor operations by reducing costs while maintaining quality.
- Productivity is determined by calculating the cost of processing the present or future year's projected workload at last year's cost with a factor added for inflation.

Operation:

- BPO annually allocates an overall dollar amount to each RO to be used for administrative costs of contractor operations.

• Contractors annually submit budgets to ROs based on projected workload and costs of operation.

• ROs negotiate actual budgeted amounts with each contractor, attempting to bring about the acceptance of more cost effective methods of operating.

• Contractors report to ROs quarterly actual expenditures which are used as a basis for budget renegotiations if workloads or costs differ significantly from projections.

Contract Experimentation

Purpose:

• To develop more effective and efficient methods and configurations for contracting Medicare operations.

Description:

• Title XVIII allows providers of health care to nominate intermediaries with which they want to deal and authorizes the Secretary to designate carriers for geographical areas in Part B. This has resulted in a noncompetitive contracting situation with reimbursement to both intermediaries and carriers based on the cost of the Medicare operations.

• Under the experimental authority given by Section 222 of P.L. 92-603, Medicare has been experimenting with contractor configurations and funding methods to find more cost effective methods of contracting without sacrificing quality of operations. These experiments include:

—Combined Part A and Part B operations.

—Fixed price and incentive contracts in which the contractor agrees to accept a fixed payment, regardless of actual costs, and accepts losses or keeps profits.

—Consolidation of small contractor operations.

Operation:

- BPO develops and issues Requests for Proposals spelling out the nature of the operations to be performed, evaluates bids, and awards contracts.
- ROs monitor and evaluate the performance of the experimental contractors, work with them to correct deficiencies, and report findings to BPO.
- BPO evaluates results of individual experimental contracts to determine the future direction of the program.

Contractor Inspection and Evaluation Program—CIEP

Purpose:

- To assess and improve the performance of Medicare contractors.

Description:

- Annual review and appraisal of each Medicare contractor designed to enhance the quality of contractor performance.
- Part A review consists of:

—Bill Processing

—Utilization Review

—Provider Reimbursement

—Provider Cost Report Settlement Process

—Beneficiary Services Activities

—Fiscal Management

—Administrative Management (including postpayment review standards/mechanisms to control abuse)

- Part B consists of:

—Claims Processing

—Coverage and Utilization Safeguards (including postpayment review standards/mechanism to control abuse)

—Program Reimbursement

—EDP Operations or Corresponding Manual Procedures

—Beneficiary Services and Professional Relations

—Fiscal Management

—Administrative Management

Operation:

- Regional Offices conduct reviews, advise Medicare contractors of findings and recommendations, prepare and follow-up on recommendations and prepare and publish the Annual Contractor Evaluation Report.
- BPO and BQC prescribe functional areas to be reviewed, but scheduling and methodology are left to the RO.
- BPO and BQC review findings to identify trends.

Performance Evaluation Program—PEP

Purpose:

- To assess and improve the performance of Medicare contractors.

Description:

- Annual review and appraisal of each Medicare contractor designed to enhance the quality of contractor performance.
- A results oriented program based on the application of specific performance criteria which measure whether a contractor has fulfilled the basic functional requirements and on statistical measures of cost and timeliness. A contractor must meet each criterion to be in compliance with the functional requirements.

Operation:

- BPO and BQC prescribe the functional areas, criteria, measures, and passing scores.
- Regional Offices conduct reviews, advise contractors of findings and recommendations, prepare ACERs, and follow up on recommendations.
- BPO and BQC review findings of individual reviews to identify national trends.

• Program has only been developed for Part A and replaces the old CIEP in Part A for FY 80. Twenty-six performance criteria are prescribed covering five basic functional areas:

—Bill Processing

—Provider Reimbursement

—Beneficiary Services

—Fiscal Management

—General Administration

Annual Contractor Evaluation Report—ACER

Purpose:

• To publish results of CIEP and PEP reviews.

Description:

• Formal report of findings and evaluation of Medicare contractor performance based on CIEP or PEP and any other reviews prepared annually.

• Includes a summary description of the contractor—its size and scope of operations in terms of number and type of providers/suppliers served, beneficiary population, total benefits paid, total bills/claims processed, administrative costs, etc.; an executive summary of the ACER minimally covering conclusions and recommendations on each major category; and an evaluation and description of findings for each category in CIEP or PEP.

Operation:

• RO writes report based on CIEP or PEP findings and uses to negotiate corrective action.

• BPO reviews reports to identify trends, develop corrective action strategy, and identify exemplary practices for use by other contractors.

Cost Report Evaluation Program—CREP

Purpose:

• To assess and improve the quality

of the Medicare cost settlement process.

Description:

- An annual program designed to measure the quality of intermediaries' reviewing, adjusting and settling of the Medicare hospital cost report including:

—adherence to policy and procedures necessary for cost report review and

—discovery of and adjustments to errors in cost reports.

- Designed to identify

—significant problem areas in the application of reimbursement principles by intermediaries,

—underlying causes of significant errors or problems noted and suggestions for improvement, and

—areas in regulations, instructions, policies, etc., which are not clear.

- Efforts currently underway to expand to cover unaudited hospital HHA and Medicaid cost reports.

Operation:

- BQC, with ORDS assistance, selects a statistically valid sample of cost reports settled by intermediaries during the period July 1 to June 30 of the previous year.

- ROs obtain copies of the sample reports, assess intermediary performance in the settlement, discuss findings, recommend corrective action to intermediaries, and prepare report of findings.

- BQC reviews RO findings to identify trends, policy areas needing change, and need for modification to the program.

Part B Quality Assurance Program

Purpose:

- To improve the quality of carrier claims payment determination.

Description:

- The program currently consists only of the Part B End of Line (EOL) Review which is a post adjudicative review of a sample of Medicare claims by the carrier that paid them and a Federal re-review of a subsample.
- Provides a portion of the basis of the claims processing evaluation in the ACER.
- Results in increased accuracy and cost savings.

Operation:

- The carrier reviews a statistically valid sample of claims with the size depending on the carrier's workload. The sample size averages about 1 percent of the total workload with variances ranging from under .8 percent to 16 percent.
- Regional Office staff conduct an onsite re-review of 10 percent of each carrier's sample.
- ROs analyze the results of EOL to determine problems and recommend corrective action.
- BPO analyzes results to identify national trends.

Validation Review Program

Purpose:

- To control abuse and waste in the Medicare Program.

Description:

- A comprehensive program designed to identify or substantiate suspected

—improper practices by institutional and non-institutional health care providers which have resulted in the payment of incorrect, excessive program funds.

—failure on the part of Medicare contractors to meet their responsibility to adequately detect and control program fraud and abuse by providers.

—weaknesses in program policy and/or its implementation which result in monies being improperly paid.

Operation:

- BQC and Regional Offices conduct onsite reviews of providers' billing practices and Medicare contractors' program payment processes.
- BQC, based on review findings, makes recommendations to appropriate components for corrective action/s, e.g.,

—recovery of program overpayments.

—investigation by the Office of Investigations of potential provider fraud.

—revision of current instructions, policies, regulations or legislation.

—improvement of existing contractor operations.

Administrative Sanctions:

Purpose:

- To ensure that Medicaid Program funds are not paid to individual providers of medical services/supplies found to have defrauded or abused the program.

Description:

- Medicaid State Agencies, on the advice of BQC, take sanction action against a provider if the provider is convicted of a criminal offense(s) related to participation in the program.

Operation:

- Regional Offices identify providers for suspension, termination, or exclusion from program participation and forward proposals to BQC.
- BQC takes suspension action on convicted providers or considers exclusion/termination action with respect to other providers.
- BQC conducts hearings, as requested by the providers, on proposed exclusions/terminations.

• BQC, after an RO investigation, acts on requests by a provider for reinstatement to program participation.

QUALITY OF CARE

The quality of care provided to beneficiaries is a major concern in both Medicare and Medicaid. Three major programs have been implemented to ensure that beneficiaries are given appropriate, high quality care:

—Standards and Certification

—Professional Standards Review Organization (PSRO)

—Utilization Review (UR)

• The standards and certification program is based on the criteria (standards) prescribed in law and regulations for providers that want to participate in the Medicare and Medicaid programs. Different standards are prescribed for each type of facility, but they are all designed to ensure that the facilities have adequate, properly trained staff to provide the type and level of care appropriate for that type of facility, as well as provide a safe physical environment for inpatients. The safety standards are prescribed in the Life Safety Code (LSC, a system designed to measure compliance with a series of *individual* standards) and the Fire Safety Evaluation System (FSES, a system that measures *overall* safety).

Compliance with these standards is ensured through an annual onsite survey of each provider by a State survey agency. The agency is under agreement with the Secretary and the Medicaid State agency to perform the surveys and thus receives both Federal and State funds. If deficiencies are identified, the facility must develop a plan of correction (POC). In Medicaid, the recommendation of the survey

agency on certification of compliance and acceptance of POCs is binding but in Medicare the HCFA Regional Offices have the decision making authority. Licensing of laboratories participating in interstate commerce under the Clinical Laboratory Improvement Act (CLIA) is now being handled as a part of this survey activity.

Those providers certified to be in compliance with the standards enter into a year-long agreement with the Secretary and/or State to participate in the programs. If certification is contingent upon the implementation of a POC, the survey agency re-visits the facility 90 days after certification to follow up on implementation.

Many hospitals are currently being surveyed by either the Joint Committee on Accreditation of Hospitals (JCAH) or the American Osteopathic Association (AOA) to ensure that they meet quality and safety standards. Those facilities accredited by JCAH or AOA are deemed to be in compliance with Medicare and Medicaid standards.

• The PSRO program is a system of peer review established by Title XI B of the Social Security Act. The program is organized, administered and controlled by local physicians who evaluate the medical necessity and quality of medical care delivered within their area under the Medicare, Medicaid, and Maternal and Child Health programs. PSROs go through 3 stages—planning, conditional, and fully designated. Three basic types of review are used—concurrent, profile analysis, and quality review. The review may be performed by the PSRO (non-delegated) or delegated to the facilities and reviewed by the PSRO. The decisions are binding on HCFA programs for payment purposes.

PSROs must enter into agreements

with the individual facilities in these areas to accept PSRO decisions as binding. To date, PSRO efforts have been aimed mainly at acute care hospitals.

PSROs are funded through grants. At the time of grant renewal, the PSRO is required to submit performance objectives for itself covering the period of the grant, as part of the grant application. These objectives were initially left to the discretion of each PSRO, but beginning in 1980, national priorities for objectives are being implemented. In the future, the performance of the PSRO will be evaluated against these priorities. The ROs review the grant application, negotiate with the PSROs and approve the grant. A major consideration in this process is driving the costs of reviews down.

- Utilization review is a system of peer review by which facilities establish committees of their staff to review the quality and appropriateness of care given to their inpatients. As PSROs expand into additional facilities and areas, UR is being phased out.

Those quality of care programs are administered through the following operational programs.

Medicare/Medicaid Automated Certification System—MMACS

Purpose:

- To provide ready and accurate data on providers participating in the Medicare and Medicaid programs.

Description:

- An automated information system that contains data on all providers certified to participate in the Medicare and Medicaid programs as well as some facilities that do not participate.

• Includes identifying information such as number of beds and type of ownership, areas of deficiencies, plan of correction dates, and agreement ending dates.

Operation:

• ROs input data from provider applications, certification and State agency survey forms.

• HSQB generates warning listings notifying State agencies when surveys are due and overdue, provider listings, provider profiles and numerous special reports on various areas of deficiencies.

PSRO Management Information System—PMIS

Purpose:

• To provide ready and accurate data on PSRO operations and their impact.

Description:

• A management information system that contains data on PSRO operations.

• Includes identifying information about the PSRO and its area, utilization data, and records of PSRO decisions.

Operation:

• PSROs perform data entry operations.

• HSQB uses the data to monitor PSROs and identify national trends.

Direct Federal Surveys

Purpose:

• To ensure that State survey agencies are making proper determinations.

Description:

• The program is designed to provide a method of evaluating State survey agency performance.

• Federal employees review providers onsite. The scopes of review vary widely from full-scale surveys to brief visits.

Operation:

• Regional Office staff conduct the surveys and compare their findings to the State findings.

PSRO Project Monitoring and Assessment

Purpose:

• To evaluate and improve the performance of PSROs.

Description:

• A dual program is currently being operated consisting of:

—A PSRO project assessment activity which is in the process of being transferred from the central office of HSQB to the ten DHHS/HCFA Regional Offices. The functional transfer will be completed on June 7, 1980.

—A PSRO Performance Monitoring System which is presently being developed by the Bureau to replace the PSRO project assessment activity. HSQB workplans target implementation August 30, 1980.

• Standardized protocols are prescribed for the evaluations that take place, with explicit instructions identifying what is to be examined, the methodology, to be used, and scoring procedures.

Operation:

• Onsite assessment are conducted by teams composed of HSQB Regional Office Personnel and special consultants with PSRO expertise. The exact composition of each individual assessment team is geared to fit the characteristics of the PSRO to be assessed. Explicit performance standards are used to locate performance deficiencies. Verbal as well as written recommendations are made to the PSRO during the assessment process. Follow-up workplans are drawn up by the Regional Project Officer to insure the implementation of the recommendations.

• Once implemented on August 30, 1980, the Report Set of the PSRO Performance Monitoring System will be used to develop a national data base to compare performance between projects at one point in time as well as over an elapsed period of time. It will also be used to determine whether certain organizational or process characteristics can be linked to outcomes of PSRO reviews.

• HSQB reviews all reports to identify national trends.

PSRO Assessment

Purpose:

• To evaluate the performance of PSROs.

Description:

• A dual program is currently being operated consisting of:

—A review of data from all PSROs every year.

—An indepth review of selected PSROs.

• A standard protocol is prescribed for the data review which provides explicit instructions as to what is to be examined, the methodology to be used, and passing scores.

• For the onsite review, the areas to be reviewed and methodology to be used are not standardized.

Operation:

• The data review is performed by the RO in the office from data already in the Office or by making telephone calls to PSROs.

• Onsite assessments are conducted by teams composed of RO and/or Central Office (CO) personnel and/or special consultants. The exact composition of the individual team is geared to fit the characteristics of the PSRO to be assessed. Deficiencies found and suggested corrective ac-

tion measures are discussed with PSRO management.

- The assessment team generates a written report of findings from each onsite assessment which is used by the RO in the administration of the PSRO grants.
- The RO prepares written reports of findings (largely statistical) from the data review, discusses deficiencies and suggested corrective actions with PSRO management, and uses findings in grant administration.
- HSQB reviews all reports to identify national trends.

Utilization Control—UC

Purpose:

- To ensure that institutionalized Medicaid beneficiaries receive proper care.

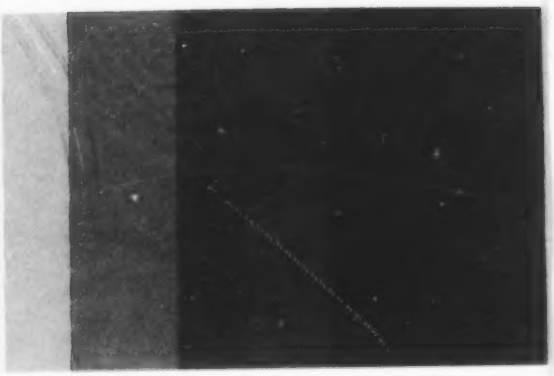
Description:

- A program by which individual patient files are reviewed on a sample basis to ensure that requirements for physician visits and treatment plans are met.
- Each facility must be reviewed annually.
- This program is dropped for all facilities accepting PSRO decisions as binding.

Operation:

- State agencies conduct onsite utilization surveys.
- ROs conduct reviews to validate State agency surveys.
- BQC assesses penalties if the review shows that a provider has not complied with the requirements.

☆ GPO : 1980 O - 329-147



U.S. Department of Health and Human Services
Health Care Financing Administration